May 14, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-03-0854-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___' IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on the ___ external review panel. This physician is board certified in anesthesiology. The ___ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History
This case concerns a 37 year-old female who sustained a work related injury on ___. The patient reported that while walking into work she slipped and fell. The patient was initially treated with heat, TENS unit, physical therapy and neck collar and back brace. The patient has undergone X-Rays and MRI of the neck and lumbar spine. The diagnoses for this patient included cervical sprain and lumbar sprain. The patient was further treated with chiropractic manipulations, passive physical medicine modalities and participated in a work hardening program.

Requested Services
Chronic Pain Management Program times 6 weeks.

Decision
The Carrier's denial of authorization for the requested services is upheld.

Rationale/Basis for Decision
The ___ psychologist reviewer noted that the patient is a 37 year-old female who sustained a work-related injury to her neck and lower back on ___. The ___ physician reviewer explained that the patient was initially diagnosed with acute cervical and lumbar strains. The ___ physician reviewer noted that the patient has been treated with oral pain medications, physical therapy, TENS unit, extensive chiropractic manipulation and work hardening. The ___ physician reviewer also noted that the patient has undergone an MRI and X-Rays of the neck and lumbar spine and underwent an evaluation by physical and rehabilitative medicine. The ___ physician reviewer further noted that the patient continues to complain of neck and back pain. The ___ physician

reviewer also explained that the patient has undergone extensive evaluations and multiple treatment interventions. The ___ physician reviewer indicated that the patient has completed a work hardening program at light functional level and was able to perform work simulation in this program. The ___ physician reviewer explained that the patient has a past medical history of rheumatoid arthritis, Sjogrens's syndrome, fibromyalgia, hypertension, depression, migraine headaches and anemia. The ___ physician reviewer indicated that these diagnoses may be responsible for her continued complaints of neck and back pain. The ___ physician reviewer explained that the documentation provided for review appears to indicate that the member's subjective complaints far outweigh the objective medical evidence. The ___ physician reviewer explained that the documentation provided does not support a diagnosis of chronic pain syndrome as a direct result of the injury incurred ___. Therefore, the ___ physician consultant concluded that the requested chronic pain management program times 6 weeks is not medically necessary to treat this patient's condition at this time.

This decision is deemed to be a TWCC Decision and Order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10 (ten)** days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20 (twenty)** days of your receipt of this decision. (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed. (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings
Texas Workers' Compensation Commission
P.O. Box 40669
Austin, TX 78704-0012

A copy of this decision should be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute. (Commission Rule 133.308(t)(2)).

Sincerely,

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 15th day of May 2003.